A Snapshot of State Experience Implementing Premium Assistance Programs

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INTRODUCTION

This report analyzes the experience of several states that have implemented premium assistance programs through Health Insurance Premium Payment program (HIPP), the State Children's Health Insurance Program (SCHIP), Health Insurance Flexibility and Accountability waivers (HIFA) or, in the cases of Oregon and Illinois, using State funds. While not a comprehensive assessment, the document is a resource for state policymakers interested in knowing how other states have implemented their programs, what their challenges and successes have been, and what impact the programs have had to date.

We set out to produce a report analyzing and weighing available research data and research evidence on these issues. However, we found relatively little research-based information—either qualitative or quantitative—on these programs. Therefore, the document relies largely on information from state reports, program descriptions, and state presentations (Attachment A).

This report does not analyze every program but focuses on states for which there is a reasonable amount of information. The report also does not reflect states' recent experience with HIFA waivers—as these programs are so new that no reports or information are yet available—or discuss state programs that are not yet implemented.

Why Premium Assistance?

Many states are considering policy strategies that use public funds to subsidize private health insurance coverage. One of the main strategies is premium assistance–wherein private insurance is subsidized for eligible people.[1] There are several reasons states are interested in premium assistance programs. First, a substantial share of low-income families may have access to employer-sponsored insurance (ESI) but are unable to afford that coverage. Buy-in programs are a way to help these families purchase private coverage. Second, states believe premium assistance programs—by leveraging public resources with private health coverage dollars—can produce significant budget savings. Third, states see premium assistance programs as a way to help stabilize private markets and prevent substitution. Finally, employer buy-in programs are attractive to many states because they rely on private markets and are consistent with the goals of individual responsibility and self-reliance.

How Large is the Eligible Population?

Premium assistance programs target low-income people who are eligible for public coverage and also have access to ESI. This is a potentially large group. Almost one quarter of poor uninsured children[2] and more than half of low-income uninsured children[3] had access to ESI in 1996 (Table

[1]Most states only use premium assistance to subsidize ESI. However, Oregon also subsidizes individual insurance policies.
[2] Children whose family income is less than 100% of FPL.
[3] Children whose family income is between 133% and 199% of FPL.

1).[4] A substantial share of children already enrolled in public programs may also have access to ESI and could be transitioned into premium assistance programs. Almost half (49 percent) of publicly covered children in low-income working families had access to ESI in 2001.[5]

Table 1: Percent of Uninsured People with Access to ESI*, by Family Income

	Family Income as a Percent of Federal Poverty Level				
	<100%	100%-132%	133%-199%	200%-249%	250%-399%
Children	23	40	55	63	51
Adults: parents	18	33	38	44	44
Adults: non parents	7	9	15	26	27

Source: IHPS Analysis of the 1996 Medical Expenditure Panel Survey
*The individual is determined to have "access to ESI" if any member of the family insurance unit was offered or is covered by ESI

Most states lack reliable data to estimate the state population eligible for premium assistance programs, but estimates produced by a few states are consistent with the overall national findings:

- **Rhode Island** estimates that about 7,000 families, or half of the 14,000 working RIte Care families, may be eligible for RIte Share, the State's premium assistance program. Approximately 4,500 companies employ these 7,000 families.
- Using survey data from Urban Institute's National Survey of America's Families, **Colorado** estimated that just over one third (36 percent) of the approximately 22,000 children eligible for Medicaid or SCHIP might be eligible for a premium assistance program because they have an employed parent with access to ESI.

What Types of Employers Might Provide Coverage Through Premium Assistance Programs?

Relatively little is known about the employers who might provide ESI coverage to these low-income families, but a few basic facts about these employers and the coverage they offer are available from state and national data:

- Large firms are more likely to participate, as the majority of children eligible for premium assistance will likely have parents working for large, not small, firms. Almost two-thirds (63 percent) of low-income uninsured children *with access to ESI* have a parent or parents working for a firm with 100 workers or more.
- Retail and professional services establishments may be more likely to participate as they employ the largest shares of uninsured workers (26 percent and 16 percent

[4] Results presented by Richard Curtis in a 2001 presentation to the 14th Annual State Health Policy Conference entitled "Employer Buy-In Programs: The Latest from the Field." These results may overestimate children's access to ESI as they do not distinguish whether the employer offers family coverage or single coverage.
[5] Strunk, Bradley, et al. "Working Families' Health Insurance Coverage, 1997-2001." The Center for Studying Health System Change, 2002. Results for families with income below 200% of FPL.

respectively). Compared to other industries, however, retail establishments are less likely to offer insurance (75 percent of retail firms offer insurance coverage).[6]

- The cost to states of the coverage provided by these employers will vary depending on the overall premium and the amount contributed by the employer. Average employer contributions to health coverage in the states analyzed in this report vary.[7] According to 2000 MEPS data, average employer contributions for small firms (those with 10 to 24 workers) ranged from a low of 55 percent of the total premium in Texas and 57 percent in Maryland to a high of 77 percent in Oregon. Average employer contributions for large firms (those with over 100 employees) did not vary much, falling between 77 and 82 percent of the total premium.

What Options do States Have?

States have several options for implementing premium assistance programs. First, they can develop them in Medicaid using Section 1906 of the Social Security Act, which instructed states to develop Health Insurance Premium Payment (HIPP) Programs. These programs use Medicaid funds to purchase employer coverage for eligible persons when such coverage is available and cost-effective. All states were required to develop HIPP programs by 1991, but the programs have since become optional. States can also implement premium assistance programs in SCHIP, following rules outlined in the SCHIP regulations, or they can use state funds to develop state-only programs.

Finally, states can implement premium assistance programs through Health Insurance Flexibility and Accountability (HIFA) waivers. Since August 2001, the Department of Health and Human Services has encouraged states to apply for these waivers. An important element of HIFA is to coordinate Medicaid and SCHIP programs with private and employer sponsored insurance (ESI). One way to do this is through a premium assistance program. HIFA provides greater flexibility for states with respect to cost-effectiveness, benefits, and cost sharing in these programs. For example, HIFA permits states to allow beneficiaries to select direct state coverage or ESI coverage. Also, in the case of optional Medicaid and SCHIP eligibles, states may allow families to enroll in their employer plans and are no longer required to offer wrap-around benefits and cost-sharing protections for these individuals. States also are not required to meet a specific cost-effectiveness test for premium assistance programs.

Tables 2 and 3 summarize the different requirements for HIPP, SCHIP, and HIFA, and program characteristics of premium assistance programs.

[6] Garrett, Bowen, et al. "Workers Without Health Insurance: Who are they and how can policies reach them?" An Urban Institute Publication for Community Voices, 2001.
[7] Data are available for Maryland, Massachusetts, New Jersey, Iowa, Oregon, Texas, and Wisconsin.

Table 2: Requirements for Medicaid HIPP, SCHIP, and HIFA Premium Assistance Programs

	Medicaid HIPP (Section 1906)	SCHIP	Additional Flexibilities through HIFA Waivers
Cost-Effectiveness	States may enroll eligibles in employer-sponsored coverage as long as the cost is not greater than the cost of direct coverage. For SCHIP, cost-effectiveness can be measured on an individual or aggregate basis.		No specific cost-effectiveness test, although states need to monitor that costs in premium assistance are not substantially higher than costs in direct coverage.
Covering Non-Eligibles	States may enroll non-eligible family members in employer coverage if this is required to obtain coverage for the Medicaid eligible(s) and it is cost-effective to do so.	States can purchase family ESI coverage through their SCHIP premium assistance programs by obtaining a family coverage waiver (under Section 2105(c)(3)). This coverage has to meet the cost-effectiveness test and cannot substitute for private coverage.	None specified
Benefits	HIPP enrollees must have access to the full range of Medicaid benefits (provided directly through ESI or through wrap-around coverage).	Children covered through premium assistance programs must be assured benefits meeting one of the SCHIP benchmarks (A) or Secretary- approved coverage (B) either through the employer plan or through wrap-around coverage.	For "optional" and "expansion" populations in premium assistance programs primary care is the only required benefit, including immunization for SCHIP eligible children.
Cost-Sharing	Cost-sharing may not exceed what is allowed for other Medicaid enrollees.	Cost-sharing for all children enrolled in SCHIP cannot exceed 5 percent of family income. Only cost sharing for the children in the family must be counted toward the cumulative cost-sharing maximum. Cost-sharing not permitted for preventive care.	No specific standard for cost-sharing.
Employer Contribution	No minimum employer contribution	States must establish a minimum employer contribution, but this standard can be below 60 percent as long as states document that employers in the state contribute less than this amount (C). States also must monitor whether substitution is occurring.	None specified
Substitution	No requirement	Eligible children must not have been covered by group health insurance coverage for the six months before enrollment in the premium assistance program, but reasonable exceptions are permitted.	None specified
Mandatory Enrollment	Enrollment can be mandatory	Enrollment can be mandatory, but if it is, employer plans must meet SCHIP standards for review of health services decisions.	None specified

Table Notes:

(A) In the January 2001 SCHIP Regulations these benchmarks are: (1) health benefits coverage offered under the FEHBP, (2) health benefits coverage in the state employee benefits plan, and (3) health benefits coverage offered by the HMO with the largest commercial enrollment in the state. Children in premium assistance programs must be provided benefits meeting one of these benchmarks or benefits that are "benchmark equivalent" (equivalent benefits determined on a benefit by benefit basis or benefits with the same or higher actuarial value) either through the employer plan or through the employer plan combined with a state-provided supplement to the employer plan. The state can use a

different SCHIP benefits benchmark for its direct coverage and its premium assistance program.

(B) As outlined in the June 2001 SCHIP Regulations, Secretary-approved coverage can include (but is not limited to) comprehensive coverage for children offered by the state under a Medicaid 1115 waiver demonstration, coverage that is the same as the coverage provided to children under the Medicaid state plan, and coverage the state demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan.

(C) Initially, SCHIP required that employers contribute a minimum of 60 percent toward premiums in order for this coverage to be eligible for premium assistance. This requirement was removed in the January 2001 SCHIP Regulations, which also outlined a number of exceptions to the six-month waiting period.

Table 3: Basic Characteristics of Premium Assistance Programs

Basic Characteristics					
State	**Source of Funds**	**Started**	**Eligibility**	**Enrollment[8]**	**Mandatory[9]**
IA	Medicaid funding	1991	All Medicaid eligibles	5,000+ eligibles and 3,000+ non eligibles as of 8/02	√
IL[10]	State dollars	1998	Children 133% to 185% FPL	5,400 children as of 11/02	**mandatory before 10/02
MA	Medicaid and SCHIP funding	1998	Families 150% to 200% FPL Also families with income under 200% FPL who work for a participating small employer.	10,000+ as of 9/02 (1,385 in SCHIP)	√
MD	SCHIP funding	2001	Children 200% to 300% FPL	162 children as of 11/02	√
NJ	Medicaid and SCHIP funding	2001	Families to 200% FPL Children to 350% FPL	119 families, 389 individuals as of 06/02	√
OR[11]	State Dollars	1998	Adults and children to 170% FPL	2,939 as of 10/02	√
PA	Medicaid funding	1995	All Medicaid eligibles	19,500 as of 6/02	√
RI	Medicaid and SCHIP funding	2002	Families to 185% FPL, Children to 250% FPL	2,200 as of 8/02	√
TX	Medicaid funding	1995	All Medicaid eligibles	6,019 as of 8/02	√
WI	Medicaid and SCHIP funding	1999	Families to 185% FPL	62 families as of 6/02	√

[8] Enrollment Figures: IA, NJ, MD, and RI (NASHP's 15th Annual Health Policy Conference presentations) OR (FHIAP website); WI (HER/RTI presentation at Child Health Services Research Meeting); PA and TX (GAO Report, 1997); IL (Application for HIFA Demonstration).

[9] If the applicant to the public program has access to qualified ESI, he or she must enroll in this coverage. In Oregon, for instance, an applicant to FHIAP with access to qualified ESI must enroll in this ESI rather than be provided a subsidy to purchase an individual policy.

[10] Illinois recently received approval for a HIFA waiver that will use title XIX and XXI funds for premium assistance.

[11] Recently approved HIFA waiver will move all qualified individuals into a Federal-state funded program. Premium assistance for individual coverage as well as employer-sponsored insurance will be available under the HIFA waiver.

Table 4 outlines the program features of the state premium assistance programs analyzed in this report.

Table 4: Features of Premium Assistance Programs

	Program Features
IA	• Eligible families can enroll in non-group or COBRA coverage if the coverage meets the cost-effectiveness test.
MA	• Premium assistance program operates as part of the state's 1115 Waiver and requires a 50% employer contribution. • SCHIP parents are covered incidental to children's coverage if this is cost-effective to cover child. • State offers small employers a subsidy payment toward the employer's share of the premium. Families covered by these employers have slightly different administrative processes for premium assistance (e.g., payments go to intermediary broker and to employers, not to families). • Premium assistance programs cover currently insured.
MD	• The premium assistance program requires a 30% employer contribution for family coverage. • Enrollment in premium assistance is a qualifying event for insured small and large businesses. The qualifying event does not apply to self-insured businesses. • Parents are not subsidized although a spouse is sometimes covered incidental to family coverage. • State has a standardized benefit package for small group employers but a side-by-side comparison is required for large employers.
NJ	• State has a standardized benefit package. • The premium assistance program requires a 50% employer contribution for family coverage.
OR	• The State's premium assistance program, FHIAP, provides coverage either through individual policies or employer buy-in. Most of people covered (about 80%) have individual policies because employer coverage is either not available or the employer does not contribute toward the premium. • FHIAP implemented Oregon's Section 1115 HIFA waiver in November, 2002. In addition to changing some eligibility criteria, the new program will be required to enroll 70-80% of the enrollees in group coverage.
RI	• Through a State law, RIte Share eligibility is a qualifying event for enrollment in ESI. • Front-end deductible plans are not subsidized. • RIte Share has no minimum or maximum employer contribution.
WI	• The premium assistance program does not cover self-insured ESI plans. • The premium assistance program covers ESI when employer's contribution is between 40% and 80%. • The program only includes families who are in BadgerCare, which covers families up to 185 percent of FPL who are not eligible for Medicaid.

The program descriptions presented in Tables 3 and 4 underscore that:

- There is considerable diversity of program rules and approaches, reflecting the diversity of state environments, insurance markets, demographics, and program goals.
- The programs are very new. Most were established in the last four years.
- Almost all states have made participation in premium assistance mandatory. That is, if program eligibles have access to qualified employer coverage they must enroll in that coverage. Eligibles without qualified employer coverage enroll in the regular Medicaid or SCHIP program or, in the case of Oregon, can purchase a subsidized individual policy.
- To date, enrollment in most programs is small.

KEY QUESTIONS AND ISSUES

This section is structured on the key questions and issues states face as they design and implement premium assistance programs. The report discusses overall findings, challenges, and successes, highlighting specific state examples for each of the following areas:

- State goals
- Identifying potential participants
- Obtaining information on health plans from employers
- Evaluating employer benefits
- Assessing cost-effectiveness of coverage
- Providing wrap-around benefits
- Making premium payments to families
- Managing cost-sharing
- Reaching out to employers and employees
- Determining resources needed
- Avoiding crowd-out

State Goals

Most states view premium assistance programs as a way to generate cost savings and support the private insurance market. Some states also see these programs as a means to reduce crowd-out.

States see premium assistance programs as an opportunity to capture resources that employers provide for health insurance coverage, producing public savings. At the same time, premium assistance programs are seen as a way to "support, not supplant" the private market and help enrollees—who may never have enrolled in employer-based coverage—transition to ESI. A number of states also see premium assistance programs as a way to prevent crowd-out, especially as states increase eligibility to families in higher income ranges who are more likely to have access to ESI.

Additional goals are to increase health care continuity and access, keep families together in the same health insurance plan, and cover more people.

Several states also believe premium assistance programs will better address the needs and preferences of some beneficiaries because: (a) children can be enrolled in the same plan as parents, potentially increasing families' willingness to enroll in coverage and their use of health care services, and (b) employer plans might provide access to a broader range of providers than SCHIP or Medicaid programs. In addition, premium assistance programs may increase coverage by attracting families who would not otherwise enroll in public coverage and covering some parents who are not directly eligible for public coverage.

Table 5: Goals of Premium Assistance Programs, by State

Goals	IA	MA	MD	OR	RI	WI
Save money by taking advantage of private dollars	√	√	√	√	√	√
Strengthen and provide bridge to ESI		√	√	√	√	√
Cover more people	√	√	√	√		
Reduce crowd-out	√	√			√	
Increase health care continuity and access	√	√	√			
Coverage for family in one plan		√	√	√		
Promote job stability	√					
Increase self-sufficiency	√		√	√		
Reach families who do not want public coverage/reduce stigma	√		√	√		
Source: State documents and personal communications with state officials.						

Identifying Potential Participants

Identifying participants can be a time-consuming process. States are looking for ways to automate the process, but available databases lack up-to-date information.

States often start their programs by moving current enrollees into the premium assistance program. They then begin recruiting new participants by including questions about employment and access to ESI on the initial program application. Some states, such as Texas, do outreach activities with employers and Medicaid beneficiaries, including mail-outs, to promote enrollment in the program.

Identifying enrollees has proved a more difficult and time-consuming process than states initially anticipated. The biggest challenge is that few people are eligible so many people must be screened to produce a few enrollees. People are not eligible for many reasons: private health insurance is not cost-effective, their employers do not offer coverage, they are not eligible for coverage that might be offered or they, or their employers, do not meet other program rules. These issues will be discussed in detail later in this report.

States have encountered a number of anticipated process challenges as they try to identify participants. These include non-response by applicants and obsolete or incomplete employer information provided by applicants. In **Wisconsin**, for instance, 25 percent of the information request forms returned by employers indicate they no longer employ the applicant. States have developed some creative approaches to identify participants, but the process remains fairly labor intensive.

State Experiences

- **Massachusetts** reviews every Medicaid and SCHIP application and refers all applicants who work (or whose parents work) to its contracted insurance investigator. The State also uses monthly enrollment files received from insurance carriers to explore whether Medicaid or SCHIP applicants are covered by ESI. This system has limits: the database cannot be used to determine if applicants have *access to,* but are

not covered by ESI, and can only track the social security numbers of parents, not children.[12]

- To identify eligibles, **Pennsylvania** includes three ESI-related questions on its application form. Similarly, **Wisconsin** identifies applicants' employers through the application form or face-to-face interviews. Not infrequently, the employer address given by the employee is incomplete or wrong. The State has looked into using an available workforce database (which identifies employers and indicates whether they offer health coverage) to extract more accurate employer contact information. By contrast, **New Jersey** has not been able to identify any databases that include employment data and health coverage information for public program enrollees.
- **Maryland** sets up telephone interviews with families of all SCHIP applicants to discuss whether they have access to employer-sponsored insurance.
- In **Iowa**, local social service eligibility offices refer employed applicants or enrollees to the HIPP office. Sometimes applicants are reluctant or unwilling to provide employment information. A small number of working enrollees are identified through computerized data matches of program enrollment files and employment information, but this information is often outdated.
- **Texas** also matches employment and Medicaid eligibility databases to identify eligibles. The State indicates that employment data are often not up to date and reports significant problems obtaining employer information from clients and convincing them to participate in the HIPP program. Reasons for non-response include client disinterest and concern they will lose Medicaid benefits if they have access to or are covered by ESI. The State has had good results with a mailing to Medicaid beneficiaries, advising them of HIPP benefits, and also with employer-focused outreach activities, including outreach efforts in partnership with local Chambers of Commerce.

Obtaining Information on Health Plans from Employers

Most employers respond to state requests for health plan information, but state experience varies in whether employers adequately respond. States have experimented with a variety of solutions from asking employees to collect the information themselves to developing databases of health plan features.

Premium assistance programs always need information from employers about the basic cost and structure of their health coverage and often need detailed information about benefits and cost-sharing. States find obtaining this information relatively time-consuming and have developed a number of approaches to streamline the process. **Oregon, Iowa**, and in some cases, **Massachusetts** ask applicants to obtain health plan information directly from their employers, believing employers will respond more positively to employee than to State agency requests.

[12] The Massachusetts processes described in this section, "Obtaining Information on Health Plans from Employers," is for large employers.

In **Iowa**, if the employee is unable to obtain plan information from the employer when requested to do so, the HIPP unit will assist by contacting the employer. The State finds that obtaining employer information has become easier over time as employer responsiveness improves and the program devises new approaches such as a database of employer plan descriptions. This database in some cases eliminates the need for employees to request information from employers. Similarly, **Rhode Island** tries to enroll all employees of an employer at the same time, asking for the employer information only once. **Texas** maintains information on major health plans and also obtains information through the beneficiary, contacting the employer only when necessary.

State Experiences

Massachusetts uses a contracted insurance investigator to follow-up with employers listed on program applications, even if the applicant indicates they do not have access to ESI. This insurance investigation is completed within 60 days. Most employers are cooperative. When they are not, employees are sometimes asked to obtain the needed information directly from employers. Even though the State maintains a database of employer health plans, it is still necessary to call employers for every new applicant. Small employers participating in the Insurance Partnership subsidy program are required to provide information about health plans and eligible employees to the State.

- Through its fiscal agent, EDS, **Wisconsin** sends all employers who are identified by applicants an information request form that includes questions about health plans offered, the cost of the plans and the employee share of the premium. If the employer does not respond to this request, EDS follows up by phone. If the employer has not responded within 56 days, eligible family members are enrolled in the regular BadgerCare program. Approximately 20-30 percent of the information request forms sent out to employers are never completed and returned. In **Maryland,** a similar proportion of employers (21 percent) do not respond to requests for information, and of those who do respond, another 22 percent do not provide sufficient information or refuse to participate. Maryland is looking into the reasons for this response rate and is considering using employees to obtain benefit information since employers may be more responsive to their employees than to the State.
- Through its fiscal agent, NHIC, Texas sends all employers and beneficiaries information about their eligibility for HIPP. NHIC staff follows up by phone, but there are a significant number of non-responses.
- In **Iowa**, Medicaid eligibility workers refer all applicants who might have access to employer coverage to the HIPP office which reviews their "benefits plan library" to find information on the employer's plan. This "library" was originally a hard-copy compilation of plans but has since been automated. If the health plan information is not available through the library, the HIPP office contacts the employee in writing to find out what benefits are covered and the employee contribution and cost-sharing amounts. If the employee does not provide the information by the requested due date, the HIPP office notifies the county office to sanction the employee's Medicaid benefits until the employee submits the information. The employee is told to call the HIPP office and request assistance if needed. If the employee requests assistance, the HIPP office will contact the employer and ask for the information directly. Most of

the time, employees are able to obtain benefits and coverage information directly from employers.

- **Oregon** requires applicants to obtain health plan information from their employers and submit this information as part of the program application. The State reports that all employers respond to employee requests for information.

Evaluating Employer Benefits

States mostly use a side-by-side approach to evaluate employer benefits for SCHIP. Some states avoid detailed analysis of benefits by assuring access to wrap-around benefits.

Enrollees in both Medicaid and SCHIP premium assistance programs must have access to the same, or similar, benefits they could obtain in direct public coverage. The specific requirements are somewhat different for the two programs.

Participants in Medicaid premium assistance programs must have access to all Medicaid services. HIPP programs provide wrap-around coverage to enrollees for any services not included in the employer plan. Because this approach assures enrollee access in every case to the full spectrum of Medicaid benefits, either through ESI or through the benefit wrap-around, HIPP programs do not generally need to complete a detailed evaluation of employer benefits. States still have minimum standards for employer benefits, but these can be quite basic. In **Wisconsin**, for example, the minimum standard—met in 99 percent of the cases—is that the employer must offer a HIPAA qualifying plan.

Enrollees in SCHIP premium assistance programs are not required to have access to exactly the same benefits they would have in direct SCHIP coverage, but employer coverage must either meet one of the SCHIP benchmarks (see Table 2 Notes A and B) or the state must provide missing benefits or services through wrap-around coverage or an insurance rider.

State Experiences

If the State decides a priori to provide missing benefits through wrap-around coverage, as in HIPP programs, states may forgo a detailed up-front review of each employer's benefits (although states still need to evaluate the overall level of benefits to calculate the cost of the wrap-around coverage for the cost-effectiveness test). **Rhode Island** has taken this approach. The State "broadly qualifies" employer plans—making sure they meet minimum requirements—and provides wrap-around services for any missing benefits. Most commercial plans meet Rhode Island's bar and qualify for RIte Share coverage. The State has adopted the philosophy that "we need to work around what the employer offers, not expect the employer plan to meet our expectations."

Other states like **Massachusetts and Maryland** avoid the complexity of wrap-around benefits by approving only those employer plans meeting their benefits benchmark. **Massachusetts** evaluates employer benefits on a side-by-side (benefit-by-benefit) basis. The State reports that this evaluation of employer plans has been very time consuming and the majority of employer plans failed to meet the State's SCHIP benchmark (commercial coverage offered by the State's

largest HMO) most commonly because they did not provide skilled nursing care.[13] In March 2002, CMS approved a SCHIP State Plan amendment approving the Medicaid benefits standard as SCHIP "Secretary-approved coverage." As a result, the State can now use this less stringent standard as the benchmark for SCHIP premium assistance coverage.

New Jersey has developed a hybrid strategy providing wrap-around services to employees in the small group market (whose coverage would not generally meet the benchmark) and conducting a side-by-side benefit evaluation—and no wrap-around coverage—to employees in the large group market.

States with a statewide-standardized benefit package can conduct one up-front evaluation of this package and provide a fixed set of wrap-around benefits to supplement the benefits if needed. **Maryland**, for example, uses the State's Comprehensive Standard Health Benefit Plan (CSHBP)—offered by the largest HMO in the State—as the SCHIP benchmark. State law requires that the CSHBP be offered by all small businesses in the State if they offer any coverage (approximately 57 percent of the State's small businesses do). Many large employer plans do not meet this benchmark.

Assessing Cost-Effectiveness of Coverage

States have a number of options for simplifying the administration of the cost-effectiveness test. The cost-effectiveness requirement does not appear to preclude a large share of families from participating in premium assistance.

States can only enroll participants in Medicaid HIPP and SCHIP premium assistance programs when doing so is cost-effective, that is, the cost of premium assistance is less than or equal to the cost of public coverage. The "cost" of premium assistance coverage may include the portion of the employee premium paid by the state, the cost of any wrap-around cost-sharing or wrap-around benefits (or benefit riders) provided by the state, and the cost of administering the program.[14] The cost may also include expenses for enrolling applicants in fee-for-service coverage while their eligibility for premium assistance is determined. For SCHIP, states may demonstrate cost-effectiveness on a case-by-case or aggregate basis. Meeting the cost-effectiveness test depends on a number of factors, some unrelated to the actual cost of ESI:

- Programs with fewer enrollees—unable to spread administrative costs over more people—may have higher per person costs and face a lower likelihood that premium assistance coverage will pass the cost-effectiveness test. This is a challenging dynamic for states in the start-up phase.
- Smaller families will have a harder time qualifying than larger ones. The *ESI cost* is typically the same for small and large families, but *state costs* for direct coverage are higher for large families, making it easier for them to qualify for premium assistance.

[13] The benefits standard used for Medicaid premium assistance (any benefit package allowed in the small group market) was less stringent. As a result, the great majority of people qualified for premium assistance program through Medicaid, not SCHIP.

[14] Some states including administrative costs in the cost-effectiveness calculation and some do not.

State Experiences

- **Rhode Island** addresses the family size issue (see above) by calculating cost-effectiveness on an "employer basis." They use the average cost of coverage to calculate cost-effectiveness for all the workers in one firm. This produces more consistent eligibility—as eligibility does not vary by family size—and greatly reduces the time and effort needed to administer the cost-effectiveness test. Rhode Island is able to do this because it has a Section 1115 waiver.
- **Iowa** bases its cost-effectiveness test on average Medicaid cost by age, sex and program group. If the employer coverage does not pass the test, program analysts investigate whether the applicant has a chronic health condition. If so, they recalculate the cost-effectiveness of employer coverage based on the specific claims data for the individual. To reduce the burden of administering the cost-effectiveness test, the State considers employer coverage automatically cost-effective when the employee premium is very low (no more than $50 for single and $100 for family coverage) or when coverage is provided for a pregnant woman.
- A few states have analyzed the proportion of employer plans that do not meet the cost-effectiveness test. In **Maryland**, seven percent of employers responding to requests for information and passing the minimum contribution requirement fail to meet the cost-effectiveness test (premium assistance coverage must be less than $195 per child per month). In **Wisconsin**, of the 127 (out of 48,967) applicants meeting all other program requirements, coverage was not cost-effective for 18. (See Assessing the Impact of Programs for more on Wisconsin's participation rates.)

Providing Wrap-Around Benefits

Paying wrap-around benefits is relatively straightforward for Medicaid but is more difficult for separate state programs.

Many states consider providing wrap-around benefits one of the more challenging and complex aspects of launching a premium assistance program. Perhaps because of this, **Massachusetts** has structured its program so that it does not provide wrap-around benefits by only approving plans that meet the SCHIP benchmark. While the state still needs to pay participants' ESI cost-sharing as a wrap-around for children with family income between 150% and 200% of the Federal Poverty Level, it does not have to provide access to benefits that are not in employer plans. The downside of this approach, as the state discovered and recently addressed, is that few employer plans met the benchmark.

While program managers acknowledge that setting up wrap-around benefit systems can be complex and administering them a bit cumbersome, they also point out that many states have the infrastructure and experience to make it work. **Iowa**, **Wisconsin**, **Virginia**, **Rhode Island**, and **New Jersey** all use the Medicaid fee-for-service system to pay wrap-around benefit claims, which works relatively smoothly.

States are more likely to encounter problems when they do not have fee-for-service payment systems or infrastructure in place to process claims and make payments. A number of separate state SCHIP programs do not have these systems. One interesting challenge faced by **Rhode Island** was the need to revamp its Medicaid payment infrastructure to pay wrap-around benefit claims after years of effort to transition all its "risk and payment" to managed care organizations.

Another issue is how to make wrap-around benefits accessible and easy to use for participants. Most states give participants a Medicaid or SCHIP insurance card participants use to cover wrap-around benefits and cost-sharing above the SCHIP or Medicaid limits. **Iowa** and **Wisconsin** employ this strategy and also ask participants to seek care from providers who participate in Medicaid, facilitating the payment process. In addition, states must decide how much to pay for wrap-around services. **Iowa**, **Texas**, and **Pennsylvania**'s HIPP programs all pay providers using the Medicaid fee schedule. **Rhode Island** decided to pay providers what they bill, believing this was key to obtaining their buy-in and cooperation.

Some enrollees and providers in Rhode Island raised concerns about the complexity of wrap-around benefits and expressed confusion about how to use the separate insurance card provided for these services. As states implement their programs, states may develop strategies to make wrap-around benefits easier to use and enrollees will likely become more accustomed to this approach.

Making Premium Payments to Families

States overwhelmingly prefer paying premium subsidies directly and prospectively to families. This reduces the burden on employers and preserves enrollee confidentiality.

In almost all cases, states pay premiums directly to enrollees. The exceptions are **Massachusetts**, which pays premiums to an intermediary and to employers for families working for small employers also receiving a state subsidy towards the employer's share of the premium, and **Wisconsin** and **Iowa**, which make payments to the employer or insurance company in the rare cases employers prefer these options. Iowa reports that over 90 percent of employers choose to have the payment sent directly to the employee. All states except **Oregon** pay participants prospectively.

Usually the first premium payment is sent to a participant once the state receives confirmation they are enrolled in ESI. To monitor continued enrollment, **Wisconsin** requires applicants to submit monthly pay stubs. **Massachusetts** conducts monthly audits matching eligibility files against enrollment files it receives from some of the largest insurance carriers.

State Experiences

- **Rhode Island** at first sent premium subsidies to employers but subsequently switched to direct employee payments. The State felt employers had a perverse incentive– since their costs increase as more employees enroll in ESI. Program managers believed employer resistance might have contributed to the initial slow growth in the program. The State switched to direct employee payments giving them more control

over participation, reducing the burden on employers, and making individual employee participation invisible to employers thereby preserving confidentiality.

- **Rhode Island** and **Iowa** reimburse employees weekly, biweekly, or monthly, depending on the frequency of the employer's payroll. Enrollees receive the subsidy checks on or about when they are paid in **Rhode Island** and two to five days before they are paid in **Iowa**.
- Fraud—which occurs when participants claim the subsidy but do not enroll in ESI coverage—has not been reported as a significant problem so far. When it paid participants prospectively, **Oregon** found that very few enrollees who received the subsidy were not enrolled in ESI coverage.

Managing Cost-Sharing

As is true for SCHIP programs in general, states need to develop mechanisms to track participant payments and ensure that enrollees do not pay more than the cost-sharing cap.

Except under HIFA, which does not have a specific cost-sharing limit, states must make arrangements to pay the difference between the generally higher cost-sharing requirements in ESI and what is permitted in the state's Medicaid or SCHIP programs. The most common approach is to require providers to bill the State for these amounts, in the same way they submit claims for wrap-around benefits.

When the public program allows some cost-sharing, but only up to a particular limit or for particular services,[15] as is often the case for SCHIP, states need mechanisms to monitor family out of pocket cost-sharing and trigger coverage when the family reaches the limit. Families enrolled in premium assistance will generally be required to track this information for themselves, as they frequently do in direct coverage programs. The situation is somewhat simpler when families are not responsible for any copayments or coinsurance, as is the case in **Rhode Island** and for many Medicaid HIPP programs, because then states can set up a wrap-around benefit that does not require a trigger.

State Experiences

- **Rhode Island** pays copayments and deductibles (the State pays the full amount billed) as part of its wrap-around benefits. These amounts are billed to Medicaid as the secondary payer.
- When families in **Massachusetts** reach the cap of 5 percent of income, families submit proof of their payments to Medicaid, which provides billing forms for participants to give providers. These forms instruct providers to bill Medicaid for any future copayments or deductibles. As a backup, if providers demand copayment at the

[15] For instance, cost sharing is not allowed for preventive services in SCHIP.

point of service, participants can pay these amounts and then request reimbursement from Medicaid.

- **Maryland** provides enrollees in premium assistance with a secondary insurance program to cover all cost-sharing imposed by the employer's plan and to ensure that the State is meeting the Federal requirements on cost-sharing. If the parent is required to pay cost-sharing for a service provided to a child, they show their secondary insurance card and the provider bills the outside contractor instead of the parent.
- Participants in **Iowa** and **Wisconsin** can use their Medicaid fee-for-service cards (provided by the State to pay wrap-around benefits and cost-sharing) to pay employer copayments so long as they use a Medicaid provider. Providers bill Medicaid as the secondary payer responsible for these amounts. As is common for secondary coverage generally, **Wisconsin** providers can only bill Medicaid once the initial payment is received from the employer's plan.

Reaching Out to Employers and Employees

Outreach to employers is critical even when they are not directly involved in the program.

States agree that establishing positive ongoing relationships with employers is very important and requires active and ongoing outreach and education. Some states have found that personal contact—including visits to employers and community groups—is by far the most effective strategy, although it is time consuming. A number of states have set up focus groups or stakeholder advisory groups to obtain employer input on program design. While states have used a variety of approaches to communicate about and market their premium assistance programs, at this early stage of program implementation it is somewhat difficult to gauge the amount of resources states have devoted to outreach or the effectiveness of these strategies.

State Experiences

- For its Insurance Partnership program for small employers, **Massachusetts** sends promotional materials to employers. Its broker partner, EBR, produced an advertising campaign to educate employers, employees, insurers, and brokers about the small business subsidy program. This campaign included television ads and radio announcements, calls to businesses, billboard advertisements, and outreach to the Chamber of Commerce. The State does not conduct outreach to large employers.
- **Texas** sends promotional materials to employers, as well as personalized letters. Texas has developed an employer outreach plan which includes visits to major employers, outreach to local and statewide Chambers of Commerce, appearances in television programs aimed to specific markets, and Web-based advertising. The State is currently working to develop radio announcements. Through the single-State agency partner, the Texas Workforce Commission, Texas educates employers and others about the tax credit program.

- **Rhode Island**'s marketing strategy included information sessions with insurers, brokers, employers, and advocates along with radio and television advertisements. An initial program evaluation indicated that enrollees and employers are still sometimes confused about how the program is structured and who is eligible, despite these efforts. The assessment recommended direct outreach, not mailings, as the best way to improve understanding and awareness.
- **Oregon** has used presentations, focus groups, direct mailings, and articles in local publications to inform employers about the program. At the outset, the State deployed three-member teams to educate stakeholders and insurance agents in local communities about the program. These teams held eighty three-hour training sessions throughout the State. Similarly, **Maryland** has used employer focus groups and interviews, redesigned communications with employers, and targeted additional outreach to important groups and industries.
- **Iowa** does not do much marketing to employers or employees, although program staff sometimes make community presentations about the program.
- Both **Oregon** and **Massachusetts** use brokers or insurance marketing representatives to market their premium assistance programs. In Oregon, insurance brokers help families enroll in individual coverage if they do not have access to ESI. Agents are paid normal market commissions by insurance carriers. In Massachusetts, marketing representatives from EBR market the Insurance Partnership.
- Feedback from employers has helped states refine their programs. Through focus groups held before its program was implemented **New Jersey** discovered that employers did not want to administer premium payments. Because of this feedback, the State decided to send premium payments directly to participants. **Wisconsin** analyzed the reasons employers were not more responsive in providing required employer health plan information. One reason was that forms and letters were not "selling" the importance of the program. The State is working to address this issue. Similarly, Maryland is considering redesigning its employer materials and strategy and has been examining other states' techniques for recruiting employers.

Determining Resources Needed

Not much information is yet available about program costs. However, two main findings are emerging: up-front costs are substantial and states may show savings even in the initial years of implementation.

At this early stage, it is difficult to assess the resources that are required to implement premium assistance programs although clearly the level of resources needed will depend on the infrastructure the state already has in place and the program design the state selects. A number of states have shared information about program costs and their calculations about whether programs have produced state savings. This information is somewhat useful but very difficult to evaluate since there is no agreed-upon methodology for calculating savings and different states report different types of information.

Clearly, though, start-up costs are substantial. Resources are needed to develop new information systems, design the program, and launch outreach and marketing campaigns. In its implementation study for a child-only ESI program under SCHIP, **Colorado** estimated it needed approximately two million dollars for program start-up with about 40 percent of this budget required for new information systems. The State's projected annual operating costs for administering the program after start-up ranged from about half a million to a million dollars depending on the program design.

Despite the substantial resource requirements to start-up and run programs, states report they are saving money even at early stages of program implementation (Table 6). These data must be interpreted cautiously, however, as we do not know how states calculated savings, some of the data are old, and information is not available for all states (including the two with the smallest enrollment, **Maryland** and **Wisconsin)**.

Table 6: Cost Savings from Premium Assistance Programs

State	Net Savings (based on state estimates)
Iowa	$18 million (1999)*
Rhode Island	$0.16 million (FY 2002)
New Jersey	$0.29 million (FY 2002)
Texas	$1.5 million (FY 2002)**
Pennsylvania	$76.4 Million (FY 2002)
*Based on a 1992 study showing every dollar spent on HIPP saves the State $3.30. ** Based on expansion of the HIPP program during SFY 2002. Texas calculates savings based on average spending of $300 per member per month.	

Avoiding Crowd-Out

States' crowd-out policies and approaches vary depending on the premium assistance option they chose and state objectives.

Some analysts believe that premium assistance programs present a *greater risk* of crowd-out than is present for public coverage generally, since families with ESI might be more likely to enroll in public coverage if they knew they could keep insurance they already have. To avoid this crowd-out risk SCHIP premium assistance programs, as well as state-only programs like Oregon's, have established "waiting periods," requirements that applicants be uninsured for a period of time before they are eligible for coverage. However, this approach can create equity problems, as families who have already insured their families through ESI are not eligible for premium assistance.

Other analysts argue that premium assistance programs help *prevent* crowd-out since some employees who are eligible for SCHIP (but would not otherwise have sought coverage in their employer's plan) will enroll in ESI, capturing the resources that employers contribute for coverage. In addition, states hope that some of these families will remain in ESI as their incomes increase, and they are no longer eligible for public coverage. Taken together, these are some of the most compelling reasons to develop premium assistance programs, report states like **Rhode Island**.

While the revised Title XXI regulations do not require a waiting period for direct SCHIP coverage, a six-month waiting period is still required for premium assistance programs. This means that some applicants will qualify for SCHIP, but not for premium assistance. Unlike SCHIP, Medicaid does not require applicants to be uninsured at the time of application.[16]

Table 7: State Crowd-Out Provisions for Premium Assistance Programs

Crowd-Out Provisions	IA	MA	MD	NJ	OR	RI	WI
Applicant cannot be covered by group health insurance at time of application or in last six months			√	√	√		√
Applicant cannot be covered by group health insurance at time of application, but no required waiting period						√*	
Applicant may be covered by group health insurance at time of application	√	√					
Note: *Must not have dropped insurance costing less than $50 in last four months.							

State Experiences

Massachusetts decided to address the equity problem, but potentially risk crowd-out, by allowing all families (regardless of whether they are insured) to enroll in its premium assistance program.

A few states have tracked the share of applicants who fail to qualify for premium assistance based on the state's crowd-out provision:

- Of the 3,109 **Maryland** cases in which employers offered qualified coverage but individuals did not qualify for premium assistance, 831 (27 percent) were disqualified because they were insured at some point in the last six months.
- In **Wisconsin**, five percent of all applicants (some of whom may not have had access to eligible employer coverage) were disqualified because they were insured at the time of application.

[16] **Wisconsin** has implemented a waiting period for Medicaid applicants under its 1115 waiver demonstration.

ASSESSING THE IMPACT OF PROGRAMS

Even though enrollment in premium assistance is modest, states are optimistic enrollment will increase and are encouraged by early reports of cost savings. Enrollment has grown rapidly in Rhode Island, for instance, increasing from 250 to 2,000 in six months. The State attributes this growth to program policies encouraging enrollment including broad qualification of employers, wrap-around benefits to supplement what employers offer, a State law making eligibility for RIte Share a qualifying event for employer coverage, no minimum employer contribution, family coverage, and an employer-based cost-effectiveness test.

By contrast, other states with narrow income bands, public coverage for children but not adults, restrictions on the types of employers or coverage that is eligible, and implementation of the program only in one segment of the publicly covered population (for instance, in SCHIP but not Medicaid) have had more modest enrollment or enrollment growth.

In **Wisconsin**, for instance, almost 50,000 employer information forms (corresponding to an equal number of applicants) were returned to the State but from these only 109 families were determined eligible and 32 families actually enrolled in the premium assistance program. The State has recently made changes to its policies—reducing the minimum employer contribution to 40 percent (from 60 percent) and making self-insured employer coverage eligible—in an effort to increase eligibility. As shown below, no one reason was responsible for the low proportion of applicants found eligible in **Wisconsin** but the layering of many requirements had a powerful impact:

- Almost a quarter of applicants (12,655 out of 48,967) no longer worked for the employer shown on their original application.
- Of the 36,312 applicants still working for the identified employer, almost 50 percent had no access to employer coverage, six percent were currently insured, and therefore not eligible, about ten percent had employer contributions that were too high (above 80 percent),[17] and almost 20 percent worked for a self-insured employer and were not eligible. These, and other reasons, eliminated 33,868 applicants.
- Of the 2,444 applicants remaining, more than 70 percent had employer contributions lower than the 60 percent level required (prior to reducing the level to 40%). This eliminated 1,789 applicants.
- Some of the eligible families could not enroll immediately, but had to wait for open enrollment in their employer plan. This is the main reason 109 families were eligible but only 32 enrolled.
- Interestingly, fewer than 400 applicants were eliminated because the employer benefits were not rich enough (the employer plan did not qualify as a HIPAA plan) and only 18 based on the cost-effectiveness test.

Even though premium assistance programs can play an important part in overall public coverage strategies, enrollment in them has been small, at least as a share of states' Medicaid or SCHIP programs. **Mississippi**, which was approved to implement a premium assistance program under

[17] The premium assistance program covers ESI when employer contributions are between 40% and 80%.

SCHIP, decided to delay implementation after analysis showed that fewer than ten percent of employer health plans would qualify and that administrative costs to launch the program would be relatively high. Wyoming decided not to implement its approved program when it received no bids from private insurance carriers, in part due to the small number of children thought to be eligible.

In **Iowa**, **Massachusetts**, **and Pennsylvania**—the states reporting the largest premium assistance enrollment—premium assistance accounts for about one percent of the Medicaid population, and in **Texas** the HIPP program enrolls less than one percent of the Medicaid population. These proportions could increase as programs mature and might be greater in states covering families with higher incomes, who are more likely to have access to ESI. At the same time, however, the states cited have relatively flexible requirements, which seem to contribute to higher enrollment. For instance, there are no minimum employer contributions in **Iowa**, **Pennsylvania**, and **Texas** and none of the states has a waiting period.

A primary reason for this relatively modest enrollment is that many families in public coverage, perhaps more than might be suggested by national data, do not have access to employer coverage. **Wisconsin**, for instance, was somewhat surprised to learn how few of its applicants had access to ESI family coverage, even though the State has higher ESI coverage rates for low-income families than many other states.[18] In **Oregon**, almost 50 percent of the children enrolled in FHIAP have parents who work full time, but many of these parents either do not have access to ESI or have employers who do not make contributions to dependent coverage. Because of this, only about 20 percent of all FHIAP enrollees are covered by ESI while the rest purchase individual policies.

For some states, a primary goal of premium assistance programs is to insure more people by covering parents of eligible children or by increasing the participation of already eligible families. The number of parents covered in this way can be substantial. **Iowa,** for example, reports that about one third of the premium assistance beneficiaries in its HIPP program are family members (mostly parents) of eligible enrollees.

Recent studies show that children are more likely to have coverage and to seek health services if their parents have insurance and seek medical care for themselves. Based on these findings, family coverage could increase the participation rates and health care utilization of children. A number of states cover families in their premium assistance programs—either directly or as a residual of children's coverage; however, states cannot yet assess the impact of these family coverage strategies on children's coverage because the programs are too new and data are not yet available to measure their impact.

A remaining question is how these programs will affect access to care, quality of care, and continuity of coverage for beneficiaries. Continuity of coverage and care may improve as a result of premium assistance programs since families enrolled in ESI might be more likely to retain this insurance when they are no longer eligible for public coverage and will be able to keep the same providers as they make this transition. However, premium assistance programs also place publicly covered people into an employer coverage system that may offer less comprehensive

[18] Data from the 1999 National Survey of American Families showed that 63 percent of low-income non-elderly adults were covered by ESI in Wisconsin compared to a national average of 51 percent.

benefits and higher cost-sharing on average than are found in Medicaid or SCHIP. Rhode Island has recently received funding for a study that will examine some of these access issues.

While premium assistance programs may help stabilize private insurance markets, as Rhode Island anticipates, and will link people to insurance they can retain as they leave public coverage, employer-sponsored insurance is not always a very stable source of coverage, especially for employees of small businesses who are more likely to drop coverage or go out of business. Indeed, **Massachusetts** reports more disenrollment from premium assistance programs than was expected, perhaps due to worker job mobility and small firm failures. Other states, targeting premium assistance to employees of larger firms who typically offer more stable coverage, may not encounter as much turnover.

Premium assistance is a key component of the new HIFA initiative, which has provided increased flexibility to states regarding cost-effectiveness, benefits, and cost sharing. The pace of program development could increase significantly as states learn from the experience and expertise of existing programs and observe the cost-savings achieved by these programs. As this growth occurs, it will be important to document state experiences, share lessons learned and assess the impact, including on participants, of these new programs.

Attachment A – Source Documents

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Attachment B – HIFA Waiver Status

Attachment B shows the current status of approved HIFA waivers as of December 2002. Additional information regarding the HIFA initiative can be found at www.cms.gov/hifa.

State	Date Received	Date Approved	Private Insurance Coordination Approach	Anticipated Coverage Expansion from HIFA Waiver
AZ	9/20/01	12/12/01	The State has proposed a feasibility study.	• Phase I: 27,000 childless adults with incomes from 0-100% of FPL. Implemented 11/1/01. • Phase II: 21,250 parents of Medicaid and SCHIP children with incomes between 100-200% of FPL. To be implemented 1/1/03.
CA	1/16/01	1/25/02	The State has proposed a feasibility study.	• 275,000 parents/legal guardians of Medicaid and SCHIP children with incomes up to 200% of FPL.
	5/8/02	9/27/02	ESI will be part of the next phase of expansions to other populations.	• 13,000 pregnant women with incomes from 134% to 185% of FPL.
DE	5/31/02	N/A	The State has proposed a feasibility study.	• 7,075 adults with income between 65% and 185% of FPL, some of whom will be uninsured upon expiration of a transitional Medicaid waiver on 10/1/02.
IL	2/15/02	9/13/02	Premium assistance (called "rebates") for employer-sponsored insurance. Many SCHIP ESI requirements are waived, such as minimum employer contribution, cost-sharing and benefit requirements.	• 300,000 (when fully implemented) parents of Medicaid and SCHIP children with incomes up to net 185% of FPL who elect to receive rebate coverage or direct coverage from the State. This includes 29,000 previously uninsured parents and 1,000 participants in State-funded programs. • Children with incomes through 185% of FPL who elect to receive rebate coverage or direct coverage from the State. • Participants in the Illinois Comprehensive Health Insurance program with net incomes through 185% of FPL who are not eligible for Medicaid coverage and do not have Medicare or other health insurance coverage. • Participants in the Illinois Hemophilia program with net incomes up to and including 185% of FPL who are not eligible for Medicaid coverage and do not have Medicare or other health insurance coverage.

State	Date Received	Date Approved	Private Insurance Coordination Approach	Anticipated Coverage Expansion from HIFA Waiver
ME	2/22/02	9/13/02	Premium assistance for employer-sponsored insurance will be offered as an option when available.	• 11,500 adults without dependents with incomes up to 125% of FPL.
NJ	7/30/02		The HIFA waiver amends the State's SCHIP program and allows the State to give Medicaid parents below 133% FPL the standard SCHIP service package (the most widely used HMO package with the largest commercial non-Medicaid enrollment marketed in New Jersey). A premium assistance program is part of the original SCHIP 1115 demonstration.	• 12,000 individuals with income below 133% FPL.
NM	4/4/02	8/23/02	The State will contract with managed care organizations to provide a new insurance product for employers to offer to their low-income workers. The policy will be purchased with a combination of State and Federal, employer and employee contributions.	• 11,000 single or childless adults with incomes up to 200% FPL. • 29,000 parents of Medicaid and SCHIP children with incomes from 37% up to 200% FPL.
OR	6/4/02	10/15/02	Premium assistance to help low-income people up to 185% FPL afford private group or individual health care coverage. Premium assistance originally implemented in 1998 up to 170% FPL; 4,000 enrollees currently served, with 22,000 on reserve list. Approved HIFA includes a flexible minimum level of benefits, cost-sharing, constant prescription drug cost-sharing level of 25% with no out of pocket maximum. Premium assistance for ESI includes portability, State continuation, COBRA.	• 60,000 individuals with incomes up to and including 185% of the FPL, some of whom are already covered in a State-funded premium assistance program.
WA	8/13/02		The State has proposed a feasibility study.	• 20,000 parents of Medicaid children and childless adults with incomes at or below 200% FPL.